

SENATE BILL No. 260

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8.

Synopsis: Waiver of preexisting conditions. Provides that an individual policy of accident and sickness insurance or a group policy of accident and sickness insurance under which a certificate of coverage is issued to an individual member of a nonemployer based association or discretionary group may contain a waiver of coverage for a specified condition under certain circumstances. Specifies that an offer of coverage under a policy that includes a waiver does not preclude eligibility for a comprehensive health insurance association policy.

Effective: July 1, 2003.

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January 9, 2003, read first time and referred to Committee on Health and Provider Services.

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First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

SENATE BILL No. 260

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 27-8-5-1 IS AMENDED TO READ AS FOLLOWS
2 [EFFECTIVE JULY 1, 2003]: Sec. 1. (a) The term "policy of accident
3 and sickness insurance", as used in this chapter, includes any policy or
4 contract covering one (1) or more of the kinds of insurance described
5 in Class 1(b) or 2(a) of IC 27-1-5-1. Such policies may be on the
6 individual basis under this section and sections 2 through 9 of this
7 chapter, on the group basis under this section and sections 16 through
8 ~~19~~ 19.2 of this chapter, on the franchise basis under this section and
9 section 11 of this chapter, or on a blanket basis under section 15 of this
10 chapter and (except as otherwise expressly provided in this chapter)
11 shall be exclusively governed by this chapter.

12 (b) No policy of accident and sickness insurance may be issued or
13 delivered to any person in this state, nor may any application, rider, or
14 endorsement be used in connection with an accident and sickness
15 insurance policy until a copy of the form of the policy and of the
16 classification of risks and the premium rates, or, in the case of
17 assessment companies, the estimated cost pertaining thereto, have been



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1 filed with the commissioner. This section is applicable also to
2 assessment companies and fraternal benefit associations or societies.

3 (c) No policy of accident and sickness insurance may be issued, nor
4 may any application, rider, or endorsement be used in connection with
5 a policy of accident and sickness insurance, until the expiration of
6 thirty (30) days after it has been filed under subsection (b), unless the
7 commissioner gives his written approval to it before the expiration of
8 the thirty (30) day period.

9 (d) The commissioner may, within thirty (30) days after the filing of
10 any form under subsection (b), disapprove the form:

11 (1) if, in the case of an individual accident and sickness form, the
12 benefits provided therein are unreasonable in relation to the
13 premium charged; or

14 (2) if, in the case of an individual, blanket, or group accident and
15 sickness form, it contains a provision or provisions that are unjust,
16 unfair, inequitable, misleading, or deceptive or that encourage
17 misrepresentation of the policy.

18 (e) If the commissioner notifies the insurer that filed a form that the
19 form does not comply with this section, it is unlawful thereafter for the
20 insurer to issue the form or use it in connection with any policy. In the
21 notice given under this subsection, the commissioner shall specify the
22 reasons for his disapproval and state that a hearing will be granted
23 within twenty (20) days after request in writing by the insurer.

24 (f) The commissioner may at any time, after a hearing of which not
25 less than twenty (20) days written notice has been given to the insurer,
26 withdraw his approval of any form filed under subsection (b) on any of
27 the grounds stated in this section. It is unlawful for the insurer to issue
28 the form or use it in connection with any policy after the effective date
29 of the withdrawal of approval. The notice of any hearing called under
30 this subsection must specify the matters to be considered at the hearing,
31 and any decision affirming disapproval or directing withdrawal of
32 approval under this section must be in writing and must specify the
33 reasons for the decision.

34 (g) Any order or decision of the commissioner under this section is
35 subject to review under IC 4-21.5.

36 SECTION 2. IC 27-8-5-2.5 IS AMENDED TO READ AS
37 FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 2.5. (a) As used in this
38 section, the term "policy of accident and sickness insurance" does not
39 include the following:

40 (1) Accident only, credit, dental, vision, Medicare supplement,
41 long term care, or disability income insurance.

42 (2) Coverage issued as a supplement to liability insurance.

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- (3) Automobile medical payment insurance.
 - (4) A specified disease policy issued as an individual policy.
 - (5) A limited benefit health insurance policy issued as an individual policy.
 - (6) A short term insurance plan that:
 - (A) may not be renewed; and
 - (B) has a duration of not more than six (6) months.
 - (7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.
 - (8) Worker's compensation or similar insurance.
 - (9) A student health insurance policy.
- (b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.
- (c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more restrictively than as:
- (1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;
 - (2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or
 - (3) a pregnancy existing on the effective date of enrollment in the plan.
- (d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.
- (e) Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and complications that directly arise from the specified condition if:**
- (1) the period for which the exemption would be in effect does not exceed five (5) years; and**

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(2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly arising from the specified condition.

(B) The:

(i) offer of coverage; and

(ii) policy;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and any related condition, complication, service, and treatment.

(C) The:

(i) offer of coverage; and

(ii) policy;

do not include waivers of coverage for more than two (2) specified conditions per individual covered under the policy.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that the individual to whom the waiver applies has not received medical advice, diagnosis, care, or treatment related to the waived condition for at least twelve (12) months, that no recommendation has been made to the individual for at least twelve (12) months that the individual should receive medical advice, diagnosis, care, or treatment related to the waived condition, and that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state or federal law.

(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of coverage waived.

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1 If a waiver is required as a condition of issuance of a policy, the
 2 applicant shall provide signed acceptance of the waiver. The
 3 applicant shall provide the signed acceptance to the insurer not
 4 more than thirty (30) days after the policy is delivered. An offer of
 5 coverage under a policy that includes a waiver under this
 6 subsection does not preclude eligibility for an Indiana
 7 comprehensive health insurance association policy under
 8 IC 27-8-10-5.1.

9 (f) An insurer shall not, on the basis of a waiver contained in a
 10 policy as provided in subsection (e), deny coverage for any
 11 condition, complication, service, or treatment that does not arise
 12 directly from the specified condition for which coverage is waived.

13 (g) An individual who is covered under a policy that includes a
 14 waiver under subsection (e) may directly appeal a denial of
 15 coverage based on the waiver by filing a request for an external
 16 grievance review under IC 27-8-29 without pursuing a grievance
 17 under IC 27-8-28.

18 (h) Notwithstanding subsection (e), an individual policy of
 19 accident and sickness insurance may not contain a waiver of
 20 coverage for treatment of a developmental disability.

21 (i) A policy that contains a waiver under this section is
 22 presumed to provide coverage for a condition, complication,
 23 service, or treatment for which coverage is not excluded under:

- 24 (1) a waiver under this section; or
- 25 (2) the terms of the policy.

26 (j) A waiver under this section may only be applied to a policy
 27 of accident and sickness insurance at the time the policy is issued.

28 SECTION 3. IC 27-8-5-19.2 IS ADDED TO THE INDIANA CODE
 29 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 30 1, 2003]: Sec. 19.2. (a) This section applies to a group policy of
 31 accident and sickness insurance:

- 32 (1) that is not employer based;
- 33 (2) that covers the members of an association or a
 34 discretionary group; and
- 35 (3) under which a certificate of coverage is issued to an
 36 individual member of the association or discretionary group.

37 (b) Notwithstanding section 19 of this chapter, a policy
 38 described in subsection (a) may contain a waiver of coverage for a
 39 specified condition and complications that directly arise from the
 40 specified condition if:

- 41 (1) the period for which the exemption would be in effect does
 42 not exceed five (5) years; and



(2) all the following conditions are met:

(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications directly arising from the specified condition.

(B) The:

(i) offer of coverage; and

(ii) certificate of coverage;

include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and any related condition, complication, service, and treatment.

(C) The:

(i) offer of coverage; and

(ii) certificate of coverage;

do not include waivers of coverage for more than two (2) specified conditions per individual covered under the certificate of coverage.

(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.

(E) The insurer agrees to:

(i) review the underwriting basis for the waiver upon request one (1) time per year; and

(ii) remove the waiver if the insurer determines that the individual to whom the waiver applies has not received medical advice, diagnosis, care, or treatment related to the waived condition for at least twelve (12) months, that no recommendation has been made to the individual for at least twelve (12) months that the individual should receive medical advice, diagnosis, care, or treatment related to the waived condition, and that evidence of insurability is satisfactory.

(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.

(G) The waiver of coverage does not apply to coverage required under state or federal law.

(H) An insurance benefit card issued by the insurer to the applicant includes a telephone number for verification of

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1 coverage waived.

2 (c) If a waiver is required as a condition of issuance of a
3 certificate of coverage, the applicant shall provide signed
4 acceptance of the waiver. The applicant shall provide the signed
5 acceptance to the insurer not more than thirty (30) days after the
6 policy is delivered.

7 (d) An insurer shall not, on the basis of a waiver contained in a
8 policy as provided in this section, deny coverage for any condition,
9 complication, service, or treatment that does not arise directly
10 from the specified condition for which coverage is waived.

11 (e) An individual who is covered under a policy that includes a
12 waiver under this section may directly appeal a denial of coverage
13 based on the waiver by filing a request for an external grievance
14 review under IC 27-8-29 without pursuing a grievance under
15 IC 27-8-28.

16 (f) An offer of coverage under a policy that includes a waiver
17 under this section does not preclude eligibility for an Indiana
18 comprehensive health insurance association policy under
19 IC 27-8-10-5.1.

20 (g) Notwithstanding subsection (b), a policy described in
21 subsection (a) may not contain a waiver of coverage for treatment
22 of a developmental disability.

23 (h) A policy that contains a waiver under this section is
24 presumed to provide coverage for a condition, complication,
25 service, or treatment for which coverage is not specifically
26 excluded under:

- 27 (1) a waiver under this section; or
- 28 (2) the terms of the policy.

29 (i) A waiver under this section may only be applied to a
30 certificate of coverage of accident and sickness insurance at the
31 time the certificate is issued.

32 SECTION 4. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999,
33 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
34 JULY 1, 2003]: Sec. 5.1. (a) Except as provided in subsections (b) and
35 (c), a person is not eligible for an association policy if, at the effective
36 date of coverage, the person has or is eligible for coverage under any
37 insurance plan that equals or exceeds the minimum requirements for
38 accident and sickness insurance policies issued in Indiana as set forth
39 in IC 27. **However, an offer of coverage described in**
40 **IC 27-8-5-2.5(e) or IC 27-8-5-19.2(b) does not affect an individual's**
41 **eligibility for an association policy under this subsection.** Coverage
42 under any association policy is in excess of, and may not duplicate,



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1 coverage under any other form of health insurance.

2 (b) Except as provided in IC 27-13-16-4, a person is eligible for an
3 association policy upon a showing that:

4 (1) the person has been rejected by one (1) carrier for coverage
5 under any insurance plan that equals or exceeds the minimum
6 requirements for accident and sickness insurance policies issued
7 in Indiana, as set forth in IC 27, without material underwriting
8 restrictions;

9 (2) an insurer has refused to issue insurance except at a rate
10 exceeding the association plan rate; or

11 (3) the person is a federally eligible individual.

12 For the purposes of this subsection, eligibility for Medicare coverage
13 does not disqualify a person who is less than sixty-five (65) years of
14 age from eligibility for an association policy.

15 (c) The board of directors may establish procedures that would
16 permit:

17 (1) an association policy to be issued to persons who are covered
18 by a group insurance arrangement when that person or a
19 dependent's health condition is such that the group's coverage is
20 in jeopardy of termination or material rate increases because of
21 that person's or dependent's medical claims experience; and

22 (2) an association policy to be issued without any limitation on
23 preexisting conditions to a person who is covered by a health
24 insurance arrangement when that person's coverage is scheduled
25 to terminate for any reason beyond the person's control.

26 (d) An association policy must provide that coverage of a dependent
27 unmarried child terminates when the child becomes nineteen (19) years
28 of age (or twenty-five (25) years of age if the child is enrolled full-time
29 in an accredited educational institution). The policy must also provide
30 in substance that attainment of the limiting age does not operate to
31 terminate a dependent unmarried child's coverage while the dependent
32 is and continues to be both:

33 (1) incapable of self-sustaining employment by reason of mental
34 retardation or mental or physical disability; and

35 (2) chiefly dependent upon the person in whose name the contract
36 is issued for support and maintenance.

37 However, proof of such incapacity and dependency must be furnished
38 to the carrier within one hundred twenty (120) days of the child's
39 attainment of the limiting age, and subsequently as may be required by
40 the carrier, but not more frequently than annually after the two (2) year
41 period following the child's attainment of the limiting age.

42 (e) An association policy that provides coverage for a family

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member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 5. IC 27-8-29-6, AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

(1) grievance filed under IC 27-8-28; or

(2) **denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2.**

SECTION 6. IC 27-8-29-12, AS ADDED BY P.L.203-2001,

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SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

- (1) an adverse determination of appropriateness;
- (2) an adverse determination of medical necessity; ~~or~~
- (3) a determination that a proposed service is experimental or investigational; ~~or~~
- (4) a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;**

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 7. IC 27-8-29-13, AS AMENDED BY P.L.1-2002, SECTION 118, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

- (1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:

- (A) appeal resolution under IC 27-8-28-17; or**

- (B) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;**

not more than forty-five (45) days after the covered individual is notified of the resolution; and

- (2) provide for:

- (A) an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

- (i) life or health; or

- (ii) ability to reach and maintain maximum function; or

- (B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

- (1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and
- (2) rotate the choice of an independent review organization

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among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider.

(6) The covered individual requesting the external grievance review.

However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.

(e) A covered individual may be required to pay not more than twenty-five dollars (\$25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer.

SECTION 8. [EFFECTIVE JULY 1, 2003] IC 27-8-5-2.5, as amended by this act, and IC 27-8-5-19.2, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

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